DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Office of the General Counsel

Public Health Division
Room 4A-53 Parklawn Bldg.
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2644

July 25, 1994

NOTE TO SCOTT H. NELSON, M.D.

Re: Scope of Federal Torts Claim Act Coverage

You have asked whether an "off-duty" IHS physician who supervises a Resident or Intern is covered for malpractice under the Federal Torts Claim Act (FTCA), see generally, 28 U.S.C. §§ 2671-2680, and § 224 of the Public Health Service Act, 42 U.S.C. § 233.

As I explained to you when we discussed this on the phone, in general, the FTCA is only applicable when the employee is acting within the scope of his or her employment. 42 U.S.C. § 233. If any part of the supervision of the Resident is considered official duties or is necessary to perform official duties, then FTCA coverage would apply. I have attached an opinion written by Regional Attorney Gary Fahlstedt which explains the general parameters of acting within the scope of employment.

However, your question was whether an IHS physician supervising a Resident outside his or her official duties is covered under the FTCA. If these duties are independent of the physician's official duties, then the FTCA does not provide any protection against malpractice claims.

If you have any additional questions or concerns, please do not hesitate to call me on (301) 443-3096. I have consulted Timothy White, Branch Chief, Business and Administrative Law Division, Office of General Counsel in providing this answer.

Edith R. Blackwell

Attachment

cc: DLR
Tim White

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Region VIII

Memorandum

Date: NOV 03 1992

From: Ronald S. Luedemann
Chief Counsel, Region VIII

08930012
BA 1030

Subject: FTCA Coverage for Care Rendered at Non-IHS Facilities

To: Thomas J. Harwood, Acting Area Director
Aberdeen Area Office, IHS

Through: Patricia R. Dunn, R.R.A.
Legal Liaison

This will respond to your memorandum of October 7, 1992 requesting our advice regarding the applicability of Federal Tort Claims Act (FTCA) protection for IHS health care professionals who provide care at non-IHS facilities. Specifically, you have asked the following questions:

1. Whether FTCA protection exists when IHS health professionals provide care to Indian patients at non-IHS facilities,

2. Whether FTCA protection exists when IHS health professionals provide care to non-Indian patients at non-IHS facilities,

3. Whether there are current limitations on FTCA coverage in such circumstances, and

4. Under what mechanisms IHS health professionals may provide services in non-IHS facilities.

As we understand it, these questions were prompted by the fact that six IHS facilities in the Aberdeen Area were recently identified as having low average daily patient loads. This information has led you to explore possible alternative means of providing inpatient care to IHS beneficiaries, and to examine, specifically, whether IHS beneficiaries in need of inpatient care could be admitted to non-IHS facilities by IHS physicians who would then follow and care for the patient in the non-IHS facility. A major concern, of course, is whether IHS health professionals would continue to be covered by the FTCA if this were done.

The FTCA, 28 U.S.C. §§ 2671-2680, and section 224 of the Public Health Service Act, 42 U.S.C. § 233, each provide immunity from personal liability for Federal employees acting within the scope of their Federal employment. The Public Health Service Act, for example, provides that suit against the United States is the sole and exclusive remedy available "for personal

injury, including death, resulting from the performance of medical, surgical, dental, or related functions . . . by any commissioned officer or employee of the Public Health Service while acting within the scope of his office or employment." 42 U.S.C. § 233, emphasis supplied. Similarly, the FTCA makes suit against the United States the exclusive remedy available for "injury or loss of property, or personal injury or death arising or resulting from the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment." 28 U.S.C. § 2679(b)(1), emphasis supplied. Thus, in determining whether the immunity protection afforded by the Public Health Service Act and the FTCA is available in any given situation, the essential inquiry is whether the employee was acting "within the scope" of his/her official employment.

IHS health care professionals who provide care to IHS beneficiaries as a part of their official duties are clearly acting within the scope of their official employment regardless of the locale at which the care is provided. Consequently, FTCA coverage applies to such a situation. Additionally, it has long been the position of this Department, as well as of the Department of Justice (DOJ), that, in certain circumstances, IHS physicians continue to be covered by the FTCA even when treating non-Indian patients in non-IHS facilities.

In a letter to this Department dated May 22, 1979, DOJ indicated that, for purposes of determining entitlement to immunity from personal liability, IHS physicians are regarded as continuing to act within the scope of their official employment when treating non-Indian patients at private facilities if they are required to treat non-Indians as a condition of maintaining hospital staff privileges at the private facility, and if maintaining such privileges is necessary in order to be able to provide inpatient care to Indians. In the typical situation, IHS physicians employed at an IHS Service Unit that lacks inpatient capability obtain clinical privileges at a local private hospital so that they will be able to admit and care for Indian patients at that facility. The private hospital will generally have medical staff bylaws that require that all physicians, as a condition of maintaining clinical privileges, perform rotating on-call duty or rotating emergency room (E.R.) duty. Obviously, when performing on-call or E.R. duty, an IHS physician may be called upon to render care to non-Indians. DOJ has taken the position that care of non-Indian patients in such limited situations is "necessarily incident to" the IHS physician's ability to provide inpatient care to Indians and, therefore, is within the scope of the physician's Federal employment.

Additionally, the Indian Health Care Amendments of 1988, Public L. No. 100-713 ("the Act"), specify that IHS may provide services to certain non-Indians under certain circumstances. Some of these authorities are restricted to the provision of care "through health facilities operated directly by the Service," (See, for example, 25 U.S.C. § 1680c(b)). However, the Act also authorizes care of non-Indians in certain circumstances, without apparent limitation regarding the location that the services are rendered. Specifically, the Act states that:

> The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to--
>
> (1) achieve stability in a medical emergency,
>
> (2) prevent the spread of a communicable disease or otherwise deal with a public health hazard,
>
> (3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post-partum, or
>
> (4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

25 U.S.C. § 1680c(c).

We conclude that an IHS health professional may provide care in a non-IHS facility to non-Indians under the circumstances enumerated in 25 U.S.C. § 1680c(c), above, and may also provide incidental care to non-Indians when required to do so as a condition of maintaining hospital privileges that are needed in order to provide inpatient care to Indians. Care provided to non-Indians under such circumstances does not remove a Federal employee from the scope of his/her employment for purposes of the FTCA. Provision of care to non-Indians in non-IHS facilities under other circumstances could, in our view, jeopardize FTCA coverage and should therefore be avoided.

Regarding the mechanisms that may be used to enter into arrangements with non-IHS facilities under which IHS health professionals could provide care in such facilities, it should be noted that the appropriate mechanism depends on a number of factors that may vary from case to case. These factors include such considerations as whether the non-IHS facility is a private facility or a facility of another Federal agency, as well as whether Federal funds will be transferred. Therefore,

it is necessary to select the appropriate mechanism on a case by case basis. There is no one mechanism that will necessarily always be appropriate. Guidance on the selection of an appropriate instrument is provided in the Department's General Administration Manual (GAM), IHS Chapter 8-78, "Guidelines for Selection of Instruments for Use with Non-IHS Entities." The referenced chapter describes the criteria for the selection and use of a variety of mechanisms including interagency and intra-agency agreements, memoranda of agreement, contracts, cooperative agreements, and collaborative agreements. A cognizant IHS office is designated as the "focal point" for advice and guidance regarding each described mechanism. Collaborative agreements are further described in IHS Chapter 8-79 of the GAM.

Please note that, in the event that a decision is made to pursue closure of any IHS inpatient units, it will be necessary to insure compliance with section 301(b)(1) of the Indian Health Care Improvement Act, 25 U.S.C. § 1631(b)(1), which provides as follows:

> Notwithstanding any provision of law other than this subsection, no Service hospital or other outpatient health care facility of the Service, or any portion of such hospital or facility, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed closure which specifies, in addition to other considerations--
>
> > (A) the accessibility of alternative health care resources for the population served by such hospital or facility;
> >
> > (B) the cost effectiveness of such closure;
> >
> > (C) the quality of health care to be provided to the population served by such hospital or facility after such closure;
> >
> > (D) the availability of contract health care funds to maintain existing levels of service; and
> >
> > (E) the views of the Indian tribes served by such hospital or facility concerning such closure.

25 U.S.C. § 1631(b)(1), emphasis supplied.

Please contact the undersigned at (303) 844-5101 if you have further questions regarding this matter.

Ronald S. Luedemann
Chief Counsel, Region VIII

By Gary Fahlstedt
Gary Fahlstedt
Assistant Regional Counsel

cc: GC:PH
IHS, Division of Legislation and Regulations